

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137a

02578

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH:

County CharlesCity or town Indian Head

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William J. Andrews4. Sex Male 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charlotte Gallaway Andrews7. Birth date of deceased (mo., day, yr.) Nov. 6 1865 6. (c) If alive, give age years8. AGE: Years 80 Months 4 Days 12 If less than one day hrs. min.9. Birthplace Accomac Co. Virginia (Town, county, and state)10. Usual occupation Ship Builder11. Industry or business John Andrews12. Name John Andrews13. Birthplace Accomac Co. Va14. Maiden name —15. Birthplace Accomac Co. Va16. Informant Geo. M. HandAddress Indian Head Md17. Burial Burial Date thereof Nov. 11 46 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory ParkleyLocation Parkley, Va18. Funeral director ChapmanAddress Washington D.C.19. Date rec'd by registrar 3-18 46 Odey Price

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Accomac (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 18 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 14 46 to Nov. 18 46and that I last saw him alive on Nov. 17 46Immediate cause of death Cerebral Hemorrhage

DURATION _____

Due to Cardio - renal

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____ Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Geo. C. Bicknell M.D.M. D. or other _____ Date signed Nov. 1946Address Maryland Md





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

02579

Reg. Dist. No. 101

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

*Charles
Mason Service*

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Bessie Lee Boswell

7. Birth date of deceased (mo., day, yr.)

Dec 25, 1870

8. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

70

2

15

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

*Tom. Boswell**Charles Co. Md.**Unknown.**Unknown.*

16. Informant

*Joe. Edward Boswell**marbury Md.**Burial**Bumpus Oak Cemetery**Baltimore**Pomona Rd.**Heintz & Ryan**Waldorf**March 9, 1946**(Date rec'd by registrar)**mary Sutherland**Local Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Charles*City or town *Mason Service* (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 8 1946 at 5:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Get. 17 1946 to March 8 1946

and that I last saw him alive on

Feb 17 1946

Immediate cause of death

*Cardio-vascular disease
central apoplexy*

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Geo. C. Becknell M.D.**M.D., mother**Marbury Md.**Date signed Mar 8 46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02580

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH: *Charles Bel airton*
County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME *James Neale Hamilton*

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *Mary Emily Hamilton*

7. Birth date of deceased (mo., day, yr.) *Sept. 6, 1867* 6. (c) If alive, give age..... years

8. AGE: Years *78* Months *6* Days *17* If less than one day hrs. min.

9. Birthplace *Charles co. Md.*
(Town, county, and state)

10. Usual occupation *Farming*

11. Industry or business *Francis P. Hamilton*

12. Name *Francis P. Hamilton*
13. Birthplace *Charles co. Md.*

14. Maiden name *Priscilla Neale*
15. Birthplace *Charles co. Md.*

16. Informant *Mary H. Muller*
Address *Bel airton, Md.*

17. Burial Date thereof *3/25/46*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *St. Ignatius*
Location *Bel airton, Md.*

18. Funeral director *Hunt & Ryan*
Address *Naedols, Md.*

19. *3-23-46* 19.....
(Date rec'd by registrar) *Julia H. Peary*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State *Md.* County *Charles*

City or town *Bel airton*
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 23, 1946* et 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 1, 1945* to *March 23, 1946*
and that I last saw him alive on 19.....

Immediate cause of death *chronic myocarditis* DURATION *14476*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

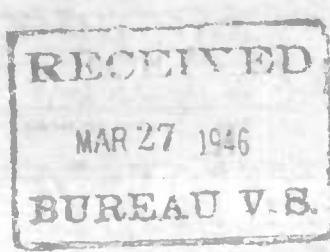
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Ernest S. Dunn, Jr. M.D.* M. D. or other

Address *Bel airton, Md.* Date signed *3-23-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

02581

Reg. Dist. No. 100

1. PLACE OF DEATH: Charles
 County.....
 City or town..... Hughesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 60 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland
 State..... County..... Charles
 City or town..... Hughesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... none

3. (a) FULL NAME
 SOPHIE S. HERBERT

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
 Female White Married
 6.(b) Name of husband or wife..... C. Posey Herbert
 7. Birth date of deceased (mo., day, yr.)..... 862 - 4 - 16
 8. AGE: Years Months Days If less than one day
 83 10 20 hrs. min.
 9. Birthplace..... Charles Co. Md
 (Town, county, and state)
 House Wife
 10. Usual occupation.....
 11. Industry or business.....
 12. Name..... Benjamin Swann
 13. Birthplace..... Charles Co. Md.
 14. Maiden name..... Sarah Odd
 15. Birthplace..... Charles Co. Md
 16. Informant..... C. Posey Herbert
 Address..... Hughesville, Md
 17. Burial..... Date thereof..... 3-8-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Old Fields Cemetery
 Location..... Hughesville, Md
 18. Funeral director..... Elmer M. Quade
 Address..... Hughesville, Md

19. Date rec'd by registrar..... 3-7-1946
 (Date rec'd by registrar) *Julia H. Posey*
 (Signature) *Registrar*

3. (b) Social Security Number
 none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 6 1946
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 March 2 1946 to March 6 1946
 and that I last saw her alive on March 6 1946

Immediate cause of death.....
Carcinoma of stomach

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

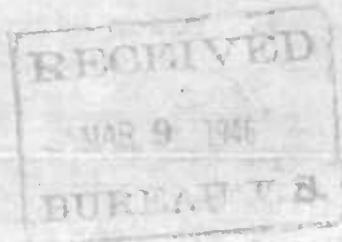
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... *D. P. Medical Examiner*
James L. MacKownagh, M.D.
 M. D. or other

Address..... *30 Plaza Rd*
 Date signed..... 3-6-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

183

02582

Reg. Dist. No. 100

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

M.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

4-20-85

8. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

60

11

16

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mrs. Vernon W. Hershberger

Location

7225-85-4th Ave Loop

18. Funeral director

Address

19. 3-7-46

19

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

7-225-6-5-4th Ave Loop, Vancouver

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-6-

1945 at 8:46 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-6

1945 to

3-6 1946

and that I last saw him alive on

3-6-46

19

Immediate cause of death

Coronary Thrombosis

3-6-46

Due to

Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

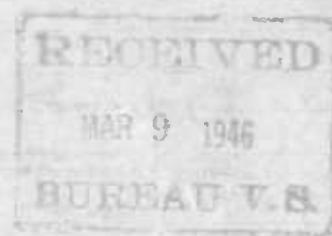
23. SIGNATURE

Address

M. D. or other

Date signed

3-6-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

02583
Reg. Dist. No. 900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: *Charley La Plata*

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: *Chesapeake Memorial Hospital*

How long in hospital or institution?.....

3. (a) FULL NAME

Constance Mudd

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife.....

William E. Mudd

7. Birth date of deceased (mo., day, yr.)

Sept 6 1875

6. (c) If alive, give age years

8. AGE: Years

70

Months

5

Days

22

If less than one day

hrs.

min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

House keeping

11. Industry or business

John Francis Mudd

FATHER

12. Name.....

John Francis Mudd

13. Birthplace

Md.

14. Maiden name.....

Imogene T. Miles

15. Birthplace

Md.

16. Informant.....

Mrs. Alice Mudd

Address

Baltimore, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof.....

3-4-46

(month) (day) (year)

Cemetery or crematory.....

St. Johns

Location.....

Clinton, Md.

18. Funeral director.....

Hunt & Ryan

Address

*Wadley Md.*19. *3-4**1946**Julian H. Bass*

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Brandywine*

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

*3-1*1946, at *5:00* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*9-6*1945, to *3-1*

1946

and that I last saw her alive on *3-1*

1946

Immediately cause of death.....

Congestive Heart Failure

DURATION

*7-7-46*Due to..... *Hypertensive Heart Disease*

9-6-45-3

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

St. Johns

M. D. or other

Address.....*La Plata Md.*Date signed *3-1-46*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7

02584

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County..... Charles
City or town..... Hughesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... life.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

SARAH CAROLINE PARKER

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

8. (b) Name of husband or wife..... Thomas Parker

7. Birth date of deceased (mo., day, yr.)..... 8. (c) If alive, give age..... years

April 7 1853

8. AGE: Years Months Days If less than one day
92 11 15 hrs. min.9. Birthplace..... Charles Co. Md.
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business

FATHER 12. Name..... George Parker

MOTHER 13. Birthplace..... Chas. Co. Md.
14. Maiden name..... Caroline Roach

15. Birthplace..... Charles Co. Md.

16. Informant..... Jeanette House
Address..... Baltimore, Md17. Burial Date thereof..... 3-25-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... St. Mary's Cemetery
Location..... Bryantown, Md18. Funeral director..... Elmer M. Quade
Address..... Hughesville, Md19. 3-23-46 19.....
(Date rec'd by registrar) *Julia H. Pasey*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Charles

City or town..... Hughesville
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war..... none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 22 1946 at 3 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 22 1946 to March 22 1946
end that I last saw her alive on

Immediate cause of death.....

Generalized arteriosclerosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings at operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

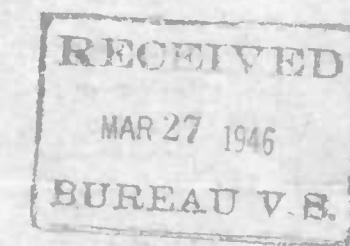
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE *James F. MacKenna, M.D.* M. D. or otherAddress..... *511 Main St., Md.* Date signed. 3-27-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11258105
Reg. Dist. No.

1. PLACE OF DEATH:

County CharlesCity or town Fa Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:

Physicians Memorial HospitalHow long in hospital or institution? 7 days

3. (a) FULL NAME

Annie Alma Swann

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Oscar Swann

7. Birth date of deceased (mo., day, yr.)

July 29

6. (c) If alive, give age

years

August 30, 1981

8. AGE:

Years
64Months
7Days
3

It less than one day

hrs. min.

9. Birthplace

St. Mary's Co. Md.

(Town, county, and state)

10. Usual occupation

House

11. Industry or business

own home

MOTHER FATHER

12. Name William Burroughs13. Birthplace St. Mary's Co. Md.14. Maiden name Anna Rebecca Burroughs15. Birthplace St. Mary's Co. Md

16. Informant

Mrs. Robert Simpson

Address

La Plata Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 7 1946
(month) (day) (year)Cemetery or crematory Christ Episcopal CemeteryLocation Chaptico St. Mary's Co. Md.

18. Funeral director

Hundt & Jackson

Address

Maryland

19. Date rec'd by registrar

19.46

D. M. D. or other

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty CharlesCity or town Fa Plata

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 4, 1946 at 12:46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 19. to 3-4- 19. 46and that I last saw her alive on March 4, 19. 46

Immediate cause of death

Congestive heart failure

DURATION

2 wksDue to Hypertensive heart disease

3-4 yrs.

Due to Chronic glomerulonephritis

8 yrs. +

Other conditions Chronic bronchitis

?

Chronic cholecystitis

?

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

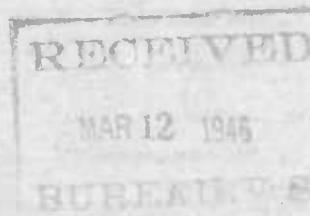
23. SIGNATURE

J. J. MacKinnon, M.D.

M. D. or other

Address

La Plata Md.Date signed 3-4-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

02586

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Audrey S. Willett

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Jan. 6, 1905

6. (c) If alive, give age..... years

8. AGE: Years

41

2

17

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Chas. co. Md.

10. Usual occupation.....

Farming

11. Industry or business

Dudley N. Willett

FATHER

12. Name.....

Chas. co. Md.

MOTHER

13. Birthplace

Mary Elizabeth Rose

14. Maiden name.....

Chas. co. Md.

15. Birthplace

Chas. co. Md.

16. Informant.....

Mrs. Louise Humphrey

Address

2548, 14 St. N.W. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Congressional

Location.....

Washington D.C.

18. Funeral director.....

Hunt & Ryan

Address.....

Maeddy, Md

19. 3-25-

19 46

(Date rec'd by registrar)

Julia A. Poore

(Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-23

1946

at 49

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940

19

to

3-23

1946

and that I last saw him alive on

you

1946

Immediate cause of death.....

Cerebral Hemorrhage

DURATION

3-23-46

Due to.....

Hypertension

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

J. S. Cullen M.D.

Address..... Date signed.....

